FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: CWA - 219952

PRELIMINARY RECITALS

Pursuant to a petition filed on September 8, 2025, under Wis. Admin. Code § HA 3.03, to review a decision by the Bureau of Long-Term Support regarding Medical Assistance (MA), a hearing was held on November 11, 2025, by telephone.

The issue for determination is whether the agency erred in its denial of IRIS enrollment.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Respondent:

Department of Health Services
201 E. Washington Ave.
Madison, WI 53703
By: H. Isidoro - TMG
Bureau of Long-Term Support
PO Box 7851
Madison, WI 53707-7851

ADMINISTRATIVE LAW JUDGE:
John Tedesco
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES #) is a resident of Milwaukee County.
2. Petitioner has applied for IRIS enrollment.

3. Petitioner was previously enrolled in IRIS from 2014 to 2024 and was ultimately involuntarily disenrolled.
4. Petitioner has a history of overspending against his IRIS budget.
5. During his previous enrollment, it was determined by the IRIS agency that [redacted] and [redacted], his roommate, were submitting payroll in [redacted]'s brother, [redacted], name.
6. On 6/3/24 petitioner informed IRIS consultant that he was coerced by his roommate, [redacted], to participate in the misrepresentation. The IC showed [redacted] copies of the signed timesheets, and [redacted] said that [redacted] had signed [redacted] name on the timesheets.
7. On 9/24/24 the agency sent notice of involuntary disenrollment from IRIS based on fraud and mismanagement. Petitioner did not appeal.
8. Petitioner re-applied for IRIS and was referred to the agency on 6/30/25.
9. Petitioner has expressed that he wishes [redacted] to be his IRIS-paid caregiver.
10. [redacted] reported to the IRIS consultant that all the issues with his previous enrollment were due to his brother, Herman. He denied participation in fraudulent or wrongful conduct, denied that [redacted] asked him to forge signatures, change hours, or falsify any other timesheet information.
11. The agency denied enrollment as a cooperative plan for services could not be agreed upon.

DISCUSSION

The Include, Respect, I Self-Direct (IRIS) program is a Medical Assistance long term care waiver program that serves elderly individuals and adults with physical and developmental disabilities. IRIS is an alternative to Family Care, Partnership, and PACE—all of which are managed long term care waiver programs. The IRIS program, in contrast, is designed to allow participants to direct their own care and to hire and direct their own workers. The broad purpose of all of these programs, including IRIS, is to help participants design and implement home and community-based services as an alternative to institutional care. *See IRIS Policy Manual §1.1B*.

The IRIS waiver application most recently approved by the Centers for Medicare and Medicaid Services (CMS) is available on-line at https://www.dhs.wisconsin.gov/iris/hcbw.pdf. See *Application for 1915(c) HCBS Waiver: WI.0484.R03.00 - Jan 01, 2021.* State policies governing administration of the IRIS program are included in the *IRIS Policy Manual* (available at http://www.dhs.wisconsin.gov/publications/P0/P00708.pdf), *IRIS Work Instructions* (available at http://www.dhs.wisconsin.gov/publications/P0/P00708a.pdf), and *IRIS Service Definition Manual* (available at https://www.dhs.wisconsin.gov/publications/p00708b.pdf).

IRIS Consultant Agencies (ICAs) are contracted by the Department of Health Services to help IRIS participants, as needed, identify paid and unpaid services that will meet their long term care needs and to then develop an "individual services and supports plan" (ISSP) that reflects those services and needs. In addition, ICAs are responsible for ensuring that the cost of paid services authorized by IRIS for a participant remain within that participant's budget amount. *IRIS Policy Manual*, §5.2B. An IRIS participant's budget is generated based on information obtained during a screening of the participant's long-term care functional needs.

"Once an IRIS participant decides upon needed services, the process for obtaining approvals for service authorizations begins. All [service plans] require [IRIS Consultant] and/or ICA approval. The participant's IC and/or ICA cannot 'approve' the ISSP when the total cost of the plan exceeds the approved budget amount." *IRIS Policy Manual*, §5.2B.

The Department has the right to deny an application for the IRIS program during the referral stage for the following reasons: cost share in arrears, substantiated fraud during a previous enrollment in IRIS or

another long term care program, living in an ineligible residential setting, or inability or unwillingness to develop an Individual Support and Service Plan (ISSP) that ensures the participant's health and safety. IRIS Policy Manual: Work Instructions, 3.3A.1. The latter ground for denial refers to "…situations wherein the participant is unwilling or unable to address the identified health and safety concerns resulting in the IRIS Consulting Agency (ICA) being unable to ensure the health and welfare of the participant as required by the 1915(c) Home and Community-Based Services (HCBS) Waiver…." Id.

The IRIS Policy Manual, quoting the waiver application, provides the following additional language regarding the ICA's obligations to ensure health and safety:

> Participation in a self-directed waiver provides participants with new opportunities, responsibilities, and risks. Finding the right balance between the participants' right to make choices with OIM's (Office of IRIS Management) obligation to ensure participant safety requires special consideration and careful planning.
>
> ICAs are required to collaborate with participants to identify potential risks and to help identify and implement strategies to mitigate identified risks. ICAs [IRIS consultant agencies] are able to define their own practices for assessing risks to participants during the ISSP [Individual Support and Service Plan] development process.
>
> OIM monitors the health and safety of participants through the record review process, which has indicators in place that ensure the ICA addressed all health and safety risks. Health and safety issues must be addressed in the ISSP based on the participant's needs and preferences.
>
> As part of risk mitigation, participants are required to have comprehensive emergency backup plans in the event that needed services are for any reason not accessible. Emergency backup plans must contain the following components:
> - Medical needs
> - Behavior needs
> - Medication and medical equipment needs
> - General overview of the participant's daily schedule
> - Contact information for emergency backup providers
> - Contact information for service providers including medical providers and the IRIS consultant
>
> Other pertinent participant-specific information ICAs may implement their own emergency backup plan format approved by OIM. All formats must provide sufficient information to ensure a backup caregiver can provide the participant with needed care to ensure the participant's health and safety in the absence of the participant's primary caregiver.
>
> The participant and IRIS consultant collaborate to develop the emergency backup plan as part of the ISSP development process. The participant and the IRIS consultant review the accuracy and effectiveness of the emergency backup plan during every face-to-face visit and every phone contact. The participant is responsible for notifying the IRIS Consultant of any changes to their emergency backup plan.

IRIS Policy Manual, § 4.1.

It is a well-established principle that a moving party generally has the burden of proof, especially in administrative proceedings. *State v. Hanson*, 295 N.W.2d 209, 98 Wis. 2d 80 (Wis. App. 1980). The court in *Hanson* stated that the policy behind this principle is to assign the burden to the party seeking to change a present state of affairs. As this case involves the denial of an application for the IRIS program, the petitioner is the moving party and must prove by a preponderance of evidence that the denial was not justified.

When reviewing a discretionary determination, a reviewing decision maker must determine if the agency erroneously exercised its discretion. *Brookfield v. Milwaukee Sewerage Dist.,* 171 Wis. 2d 400, 423 (1992). This term replaced the prior term "abuse of discretion" in Wisconsin law. The standard of review, however, remains the same. An erroneous exercise of discretion is when a decision maker fails to apply the appropriate legal standard to the relevant facts. *Hedtcke v. Sentry Ins. Co.,* 109 Wis. 2d 461, 471, (1982). "The exercise of discretion must depend on facts that are of record or that are reasonably derived by inference from the record and the basis of the exercise of discretion should be set forth." *Howard v. Duersten,* 81 Wis. 2d 30, 305 (1977). Thus, if a discretionary action has a rational basis, it is not an erroneous use of discretion.

The question here is whether the petitioner has demonstrated, by a preponderance of the credible evidence, that the respondent erroneously exercised its discretion when it denied the petitioner's IRIS application.

Notwithstanding the respondent's denial of his IRIS application based upon safety concerns, an inability to collaborate with his mother/caregiver/guardian, and issues concerning overbilling, petitioner is otherwise arguably eligible for IRIS enrollment.

IRIS policy requirements provide:

> The Centers for Medicare and Medicaid Services (CMS) require an assessment of IRIS participants' needs and preferences. CMS further requires IRIS participants' Individual Support and Service Plans (ISSPs) to address all needs and preferences identified in the assessment. CMS requires a person-centered approach during ISSP development.
>
> The approved 1915 (c) Medicaid Home and Community Based Services (HCBS) waiver states in Appendix E (E-1):
>
> "Using the person-centered approach, the Individual Support and Service Plan revolves around the individual participant and reflects his or her chosen lifestyle and culture. Planning occurs where, when and with whom the participant chooses. The participant directs development of the Plan, which serves as the foundation for participation in this waiver."
>
> The approved 1915 (c) Medicaid HCBS waiver describes the aforementioned assessment process in Appendix D (D-1):
>
> "Person-centered planning includes a discovery process, e.g., assessment process. There are tools, resources, and information available to help participants express their needs and the IRIS Consultant will assist the participant in using a risk assessment to identify strengths and weaknesses that may impact the participant's health and welfare. In addition to the discovery process, participants and IRIS Consultants may have access to

> information from the LTC FS assessment and content area experts. All ICAs will have initial conversations with participants to explore the following areas:
>
> 1. Long-term care outcomes
> 2. Strengths and capacities, including the areas of strength for the participant and the natural supports and other resources available
> 3. Accomplishments, e.g., areas of skill
> 4. Personal relationships with family and friends
> 5. Community life, memberships, associations, and faith communities
> 6. Work, school or other daily activities
> 7. Health status and service needs
> 8. Risk factors
>
> As authorized by CMS through the approved 1915 (c) HCBS waiver, the Department of Health Services (DHS) requires each IRIS participant to maintain a current ISSP with achievable outcomes, including a back-up plan. DHS requires the ISSP to contain the type, scope, amount, duration, and frequency of authorized services. IRIS Consultants (ICs) update the IRIS participants' ISSP at least annually or when the needs of the IRIS participant change.

IRIS Policy Manual, §5.0.

The respondent has presented testimony and documentary evidence demonstrating multiple instances which have caused the agency to believe that in a self-directed program, in which petitioner and his representatives are making critical choices, the agency will be unable to collaborate to ensure the creation of an appropriate ISSP. The agency questioned the judgment and decision making of petitioner and his role is prior fraudulent actions involving his previous IRIS enrollment, as well as his unwillingness to accept any responsibility for wrongful action under the IRIS case he was self-directing. The petitioner did not convincingly rebut any of the agency's assertions but only deflected.

There is no entitlement to become enrolled in IRIS. In this case the IRIS program does not believe that the program is right for petitioner. The agency is concerned that petitioner may suffer harm, injury, or a lack of essential services if he becomes a member of the program because the program lacks the structure that the agency believes is necessary to support his goals. The agency lacks confidence that funds will not be mismanaged or that petitioner will be safe from manipulation by others. The agency is permitted to deny enrollment under such circumstances.

The agency's decision to deny enrollment is justified and not arbitrary. The petitioner has not established a basis to overturn the agency's determination that it cannot create a plan that keeps petitioner safe. This denial does not prevent the petitioner from seeking assistance through the Family Care program, which has more oversight as it is not self-managed. Should he qualify, the Family Care program can provide the petitioner with the personal care worker services that he undoubtedly needs. Wis. Admin. Code § DHS 10.41(2), Note.

CONCLUSIONS OF LAW

The agency was within its discretion in denying enrollment to petitioner based on its belief that it could not ensure his safety and health and avoid financial mismanagement.

THEREFORE, it is **ORDERED**

That this appeal is dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision.** Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 4822 Madison Yards Way, 5th Floor North, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 201 E. Washington Ave., **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Madison,
Wisconsin, this 10th day of December, 2025

\s_____
John Tedesco
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

Telephone: (608) 266-7709
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on December 10, 2025.

Bureau of Long-Term Support